REFERRAL FOR CCS / PHYSICIAN PRESCRIPTION

Two page form – both pages required

Consumer Name:

Date of Birth: Age:

Social Security Number:

What is the best way to reach the consumer?

Consumer Address:

Did anyone assist the consumer with this referral? ☐ YES ☐ NO

If yes, please list the name and agency:

Agency preference for the Screen & Assessment (circle one):

APC La Causa TLS Horizon St. Charles No Preference

Return Referral/Prescription to:

CARS
9201 Watertown Plank Road
Milwaukee, WI 53226
Fax: 414-454-4242

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Consumer Name:

Date of Birth: Age:

Social Security Number:

Please have your Psychiatrist or Physician complete the information below.

CCS may be able to provide psychosocial rehabilitative services that meets a person's needs.

Psychiatric Diagnosis:

List other relevant diagnoses (including severity specifiers where indicated):

I, the undersigned, prescribe Comprehensive Community Services (CCS) for _____ _____ with Milwaukee County.

Psychiatrist or Physician signature:

X _____

Date (Prescription signed):

This annual prescription will expire one year from the date of signature.

Legibly printed or typed name of prescriber:

Agency/Clinic: